

AUTHORIZATION FOR USE/DISCLOSURE OF INFORMATION

I hereby authorize: _____
(Person, facility, or class of persons)

To disclose my health information to: _____
(Person, facility, or class of persons)

Street Address _____ City _____ State _____ Zip _____

If you have an on-going medical condition (e.g. diabetes, epilepsy, allergies, etc.), please ask your current healthcare provider to forward pertinent medical information or no more than the last three years of medical history to Student Health Services (SHS). When requested, SHS will routinely provide up to three years of your medical history to other healthcare providers. SHS can provide additional information when necessary.

Information to be disclosed is to include these dates: Dates specified: _____
 Past 3 years

(If ALL information were to be disclosed, it could include the past three years of the following: Notes by physicians, physical therapy, dietary, etc.; phone messages, test and x-ray results; immunization information; medical history; referrals, correspondence and copies of completed health forms.)

Information to be disclosed: _____

Information listed below will **NOT** be routinely disclosed **unless initialed** for authorization:

- | | |
|--|---|
| _____ Alcohol/Drug Abuse Treatment records | _____ Mental Health |
| _____ Abortion information | _____ STI's (Sexually Transmitted Infections) |
| _____ AIDS (Acquired Immune Deficiency Syndrome) | _____ Sexual Orientation |
| _____ HIV (Human Immunodeficiency Virus) | _____ Records from Outside Sources |

Purpose of Use/Disclosure: _____

I am requesting a copy of the documentation regarding my illness / injury for use in explaining class absence(s).
PLEASE NOTE: Include my diagnosis DO NOT include my diagnosis

I understand that once the uses/disclosures have been made as permitted by this form, the records/information may be subject to re-disclosure and no longer protected by federal privacy regulations. I understand that I may refuse to sign this authorization and that will not affect my ability to obtain treatment. I understand that I may revoke this authorization at any time by delivering in writing a revocation to Student Health Services, but if I do, it will not have any effect on actions the Clinic took in reliance on this authorization prior to receiving the revocation. I authorize the use/disclosure of the records/information described above.

Specify the date or condition upon which this consent expires: _____
(Not to exceed one year)

_____ Patient's Signature	_____ Patient's Name Printed	_____ Date
_____ Street Address	_____ City	_____ State _____ Zip
_____ Phone Number	_____ Date of Birth	_____ KUID
_____ Signature of Parent, Guardian, or Authorized Representative	_____ Please Print Name	_____ Date
_____ Street Address	_____ City	_____ State _____ Zip

Description of Legal Representative's Authority to act for Patient

***** PREPAYMENT OF CHARGES FOR DUPLICATION OF RECORDS IS REQUIRED*****

Please allow ten business days for processing

No charges if records sent to a health care provider

Reviewed by: _____ **Charges** _____ **Date sent** _____